BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: KENNETH BRAULIO ALONSO, M.D. 203 B Medical Way Riverside, Georgia 30274 Physician's and Surgeon's Certificate No. G-73252, Respondent.	)	No. 16-95-50349 OAH No. N-9511001

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Medical Board of California as its Decision in the above-entitled matter.

This Decision shall become effective on March 29, 1996.

IT IS SO ORDERED February 28, 1996.

OAH 15 (Rev. 6/84)

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	No. 16-95-50349
KENNETH BRAULIO ALONSO, M.D. 203 B Medical Way Riverside, Georgia 30274	)	OAH No. N-9511001
Physician's and Surgeon's Certificate No. G-73252,	)	
Respondent.	)	

PROPOSED DECISION

The matter came on regularly for hearing before Jaime René Román, Administrative Law Judge, Medical Quality Hearing Panel, Office of Administrative Hearings, Sacramento, California, on December 4, 1995. Complainant was represented by Jana L. Tuton, Supervising Deputy Attorney General, Health Quality Enforcement Section-Sacramento, California Department of Justice. Respondent Kenneth Braulio Alonso, M.D. (hereinafter "Respondent"), having been provided notice of the time, date and place for hearing, failed to appear.

Evidence was received and the matter deemed submitted on December 4, 1995.

The Administrative Law Judge finds the following:

* * * * *

FINDINGS OF FACT

Procedural Findings

I

Complainant, Dixon Arnett, Executive Director of the Medical Board of California (hereinafter "the Board"), brought the Accusation on August 10, 1995, in his official capacity.

II

On January 14, 1992, Respondent was issued Physician and Surgeon's Certificate No. G-73252 by the Board.

Factual Findings

III

At all times relevant, Respondent was issued license number 016011 to practice medicine in the State of Georgia.

IV

On January 5, 1995, Respondent's license in the State of Georgia (Finding No. III) was disciplined by the Board of Medical Examiners, State of Georgia, in a matter entitled In the Matter of: Kenneth B. Alonso, M.D., Case No. 91-259 for unprofessional and unethical and dangerous conduct related to the practice of medicine. In his treatment of six patients, Respondent failed to comport with the minimal standards of acceptable and prevailing medical practice. As a consequence of his treatment, four patients died. The discipline imposed by the Board of Medical Examiners in the State of Georgia included a public reprimand and a three year term of probation on various terms and conditions, including, inter alia, a suspension from the practice of medicine for six months, a prohibition from treating cancer patients until Respondent became a Board-certified oncologist, and a fine in the sum of $10,000.00.

V

Respondent, having failed to appear, no evidence of mitigation, rehabilitation or extenuation was presented.[1]

---

[1]The Administrative Law Judge is reluctant to engage in conjecture as to the extent, if any, of Respondent's remorse, insight or other mitigating evidence. See In the Matter of Boyne (1993) 2 Cal. State Bar Ct. Rptr. 389, 406.

Costs Findings

VI

Costs and fees in the sum of $600.00 have been reasonably paid and incurred by the Board in the investigation and prosecution of this matter.

* * * * *

DETERMINATION OF ISSUES

Pursuant to the foregoing Findings of Fact, the Administrative Law Judge makes the following Determination of Issues:

I

Cause exists to revoke or suspend the certificate of Respondent as a physician and surgeon for discipline imposed by another state pursuant to the provisions of Business and Professions Code sections 2234 and 2305 as set forth in Finding Nos. III - IV. Marek v. Board of Podiatric Medicine (1993) 16 Cal.App.4th 1089, 1093.

II

Cause exists to direct Respondent to pay $600.00 as costs in the investigation, prosecution or enforcement of this matter pursuant to Business and Professions Code section 125.3 as set forth in Finding No. VI.

III

The objective of this proceeding is to protect the public, the medical profession, maintain professional integrity, its high standards, and preserve public confidence in the medical profession and its particular physicians and surgeons. These proceedings are not for the primary purpose of punishing an individual, particularly Respondent. Camacho v. Youde (1979) 95 Cal.App.3d 161, 165; Marek, supra at pp. 1099 - 1100.

Accordingly, giving due consideration to the facts and circumstances underlying the Accusation (Finding Nos. III - IV) and the lack of evidence in mitigation or rehabilitation (Finding No. V), the public interest will be adversely affected by the continued issuance of a license to Respondent.

* * * * *

ORDER

WHEREFORE, THE FOLLOWING ORDER IS HEREBY MADE:

1. Certificate No. G-73252 issued to Respondent Kenneth Braulio Alonso, M.D., is revoked.

2. Respondent Kenneth Braulio Alonso, M.D, is ordered to reimburse the Division of Medical Quality the amount of $600.00 within 90 days of the effective date of this Decision for its investigative and prosecution costs.

Dated: December 7, 1995

JAIME RENÉ ROMÁN
Administrative Law Judge
Medical Quality Hearing Panel
Office of Administrative Hearings

DANIEL E. LUNGREN, Attorney General
of the State of California
JANA L. TUTON
Supervising Deputy Attorney General
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, California 94244-2550
Telephone: (916) 324-5342

Attorneys for Complainant

BEFORE THE DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: KENNETH BRAULIO ALONSO, M.D. 203 B Medical Way Riverside, GA 30274 Physician's & Surgeon's Certificate No. G73252 Respondent.	No. 16-95-50349 **ACCUSATION**

Dixon Arnett, for causes for discipline, alleges:

1. Complainant Dixon Arnett makes and files this accusation solely in his official capacity as Executive Director of the Medical Board of California (hereinafter referred to as the "Board") and not otherwise.

2. On or about January 14, 1992, the Medical Board of California issued Physician's and Surgeon's Certificate Number G73252 to Kenneth Braulio Alonso, M.D. The certificate will expire November 30, 1995, unless renewed.

/ / /

/ / /

3. Under Business and Professions Code section 2234, the Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct.

4. Under Business and Professions Code section 125.3, the Division may request the administrative law judge to direct any licentiate found to have committed a violation or violations of the licensing act, to pay the Division a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

5. Under Business and Professions Code section 2305, the revocation, suspension, or other discipline by another state of a license or certificate to practice medicine issued by the state shall constitute unprofessional conduct against such licensee in this state.

6. Respondent has subjected his physician's and surgeon's certificate to discipline under Business and Professions Code sections 2234 and 2305 in that on or about January 5, 1995, the State of Georgia Composite State Board of Medical Examiners (hereinafter "Georgia Board") issued a Final Order against respondent. The Georgia Board suspended respondent's license to practice medicine for six (6) months, placed respondent on probation for three (3) years with terms and conditions, prohibited respondent from treating cancer patients at anytime in the future unless he should become a Board-certified oncologist, and ordered respondent to pay a fine in the sum of ten thousand ($10,000) dollars. The Georgia Board's order was also to serve as a public reprimand. (See attached Exhibit "A.") The Georgia Board's allegations were as follows:

(A) Respondent is Board-certified in anatomic and clinical pathology, nuclear medicine and forensic medicine. However respondent is not Board-certified in internal medicine or oncology;

(B) Respondent was responsible for the treatment of approximately six cancer patients for which he failed to comply with the minimal standards of acceptable and prevailing medical practice;

(C) As a result of respondent's failure to follow the standard protocol in performing bone marrow transplantations, including but limited to proper maintenance of a sterile environment and proper use of antibiotics, three of respondent's patients (one suffering from non-Hodgkin's lymphoma, one suffering chronic granulocytic leukemia, and one suffering from breast cancer which had metastasized to the lungs, liver, brain and bone) died due to infection;

(D) Respondent concurred with a plan for a patient suffering from liver cancer to undergo surgery to implant an infusion pump to infuse the patient's liver with chemotherapy. The patient subsequently bled to death during the surgical procedure.

WHEREFORE, complainant prays that a hearing be held and that the Medical Board of California make its order:

1. Revoking or suspending Physician's and Surgeon's Certificate Number G73252, issued to Kenneth Braulio Alonso, M.D.;

2. Prohibiting Kenneth Braulio Alonso, M.D. from supervising physician assistants;

3. Awarding the Board the reasonable costs of the investigation and prosecution of this proceeding; and

4. Taking such other and further action as may be deemed proper and appropriate.

DATED: 8-10-95

DIXON ARNETT, Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

03573-160-SA95AD1109
(PAW 8/2/95)

EXHIBIT A

MAX CLELAND
Secretary of State

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS
William G. Miller, Jr., Joint Secretary, State Examining Boards
166 Pryor Street, S.W.
Atlanta, Georgia 30303-3465
(404) 656-3913

TO WHOM IT MAY CONCERN:

I, Andrew Watry, Executive Director, of the Composite State Board of Medical Examiners and records custodian of same, do hereby certify that the attached Initial Decision docketed July 5, 1994, Final Order docketed January 6, 1995 are true and correct copies of the original documents on file with the Georgia Medical Board in the matter of **Kenneth Braulio Alonso, M.D.**

This 5th day of July 1995

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS

Andrew Watry

Andrew Watry, Executive Director

Sworn to and subscribed before me

this 5th day of July 1995

Charlotte L Austin
NOTARY PUBLIC

My Commission Expires 9-22-98

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS
William G. Miller, Jr., Joint Secretary, State Examining Boards
166 Pryor Street, S.W.
Atlanta, Georgia 30303-3465
(404) 656-3913

TO WHOM IT MAY CONCERN:

I, Andrew Watry, Executive Director, of the Composite State Board of Medical Examiners and records custodian of same, do hereby certify that the attached Notice of Hearing docketed January 6, 1995 is a true and correct copy of the original document on file with the Georgia Medical Board in the matter of **Kenneth Braulio Alonso, M.D.**

This 13th day of June 1995

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS

Andrew Watry, Executive Director

Sworn to and subscribed before me

this 13th day of June 1995

NOTARY PUBLIC

My Commission Expires 12-10-98

Exhibit

BEFORE THE COMPOSITE STATE BOARD OF MEDICAL EXAMINERS

STATE OF GEORGIA

IN THE MATTER OF:	)	
	)	DOCKET NO. _____
KENNETH BRAULIO ALONSO, M.D.,	)	
License No. 016011,	)	AG NO. 96004-90-JBA
	)	
Respondent.	)	

TO: Kenneth Braulio Alonso, M.D., Respondent
2921 Margaret Mitchell Court, N.W.
Atlanta, Georgia 30327

Philip C. Henry
10 Park Place South
Suite 510
Atlanta, Georgia 30303

NOTICE OF HEARING

You are hereby notified that the Composite State Board of Medical Examiners, through its appointed representative, will hold a hearing at the offices of the Board, 166 Pryor Street, S.W., Atlanta, Georgia 30303, at 10:00 o'clock, a.m., on the 20th day of August, 1991, for the purpose of hearing charges that, if proven, may result in suspension, revocation or other disciplinary action against your license to practice medicine in the State of Georgia. You are also notified of the following matters:

LEGAL AUTHORITY FOR HEARING

This hearing will be held under the authority and jurisdiction conferred upon the Composite State Board of Medical Examiners by O.C.G.A. Chs. 1 and 34, T. 43, as amended,

O.C.G.A. § 43-1-19 and in accordance with the Administrative Procedure Act, codified in O.C.G.A. Ch. 13, T. 50, as amended, the Rules and Regulations of the Composite State Board of Medical Examiners and the Rules and Regulations of the Joint Secretary, State Examining Boards.

HEARING OFFICER

Pursuant to the provisions of O.C.G.A. Ch. 13, T. 50, the Composite State Board of Medical Examiners hereby appoints the hearing officer designated below as hearing officer for the above-styled matter.

NAME: _____

ADDRESS: _____

_____

_____

TELEPHONE: _____

The hearing officer shall have the authority to exercise those powers on behalf of the Board enumerated in O.C.G.A. § 50-13-13(a)(6) or elsewhere in the Georgia Administrative Procedure Act or the rules of the Joint Secretary, as adopted by the Board, in conducting the hearing.

RIGHTS OF RESPONDENT

You have the following rights in connection with this hearing:

(1) To respond and to present evidence on any relevant issue;

(2) to be represented by counsel at your expense;

(3) to subpoena witnesses and documentary evidence through the Board by filing a request with the Joint Secretary;

(4) such other rights as are conferred by the Rules and Regulations of the Board and the Rules and Regulations of the Joint Secretary, State Examining Boards.

FILING OF ANSWER AND OTHER PLEADINGS

An Answer to this Notice of Hearing must be filed within fourteen (14) days after receipt of service of this Notice. The original and one duplicate of the Answer and any subsequent pleading or response, each designated as "Original" and "Duplicate" by appropriate marking or stamp, should be filed with the Docket Clerk of the Joint Secretary, 166 Pryor Street, S.W., Atlanta, Georgia 30303. An additional copy of the Answer and any subsequent pleading or response should also be sent to or served upon counsel for the Board, whose name and address appear on the last page of this Notice.

STATUTES AND RULES INVOLVED

Sanction of the Respondent's license is sought pursuant to the following provisions of O.C.G.A. § 43-34-37:

(a) The board shall have authority to refuse to grant a license to an applicant or to discipline a physician licensed under this chapter or any antecedent law upon a finding by the board that the licensee or applicant has:

(7) Engaged in any unprofessional, unethical, deceptive, or deleterious conduct or practice harmful to the public, which

conduct or practice need not have resulted in actual injury to any person. As used in this paragraph, the term "unprofessional conduct" shall include any departure from, or failure to conform to, the minimal standards of acceptable and prevailing medical practice and shall also include, but not be limited to, the prescribing or use of drugs, treatment, or diagnostic procedures which are detrimental to the patient as determined by the minimal standards of acceptable and prevailing medical practice or by rule of the board;

(10) Violated or attempted to violate a law, rule, or regulation of this state, any other state, the board, the United States, or any other lawful authority without regard to whether the violation is criminally punishable, which law, rule, or regulation relates to or in part regulates the practice of medicine, when the licensee or applicant knows or should know that such action is violative of such law, rule, or regulation; or violated a lawful order of the board, previously entered by the board in a disciplinary hearing;

O.C.G.A. § 43-1-19(a) provides that a state examining board shall have the authority to refuse to grant a license to an applicant therefor or to revoke the license of a person licensed by that board or to discipline a person licensed by that board, upon a finding by a majority of the entire board that the licensee or applicant has:

(6) Engaged in any unprofessional, immoral, unethical, deceptive, or deleterious conduct or practice harmful to the public, which conduct or practice materially affects the

fitness of the licensee or applicant to practice a business or profession licensed under this title, or of a nature likely to jeopardize the interest of the public, which conduct or practice need not have resulted in actual injury to any person or be directly related to the practice of the licensed business or profession but shows that the licensee or applicant has committed any act or omission which is indicative of bad moral character or untrustworthiness; unprofessional conduct shall also include any departure from, or the failure to conform to, the minimal reasonable standards of acceptable and prevailing practice of the business or profession licensed under this title.

(8) Violated a statute, law, or any rule or regulation of this state, any other state, the state examining board regulating the business or profession licensed under this title, the United States, or any other lawful authority (without regard to whether the violation is criminally punishable), which statute, law, or rule or regulation relates to or in part regulates the practice of a business or profession licensed under this title, when the licensee or applicant knows or should know that such action is violative of such statute, law, or rule; or violated a lawful order of the board previously entered by the board in a disciplinary hearing, consent decree, or license reinstatement.

Respondent is also alleged to have violated Board Rule 360-2-.09, which relates to or in part regulates the practice of medicine, and provides in pertinent part as follows:

The Board has the authority to refuse to grant a license to an applicant, or to discipline a physician licensed in Georgia if that physician has engaged in unprofessional conduct. For the purpose of the implementation and enforcement of this rule, unprofessional conduct is defined as, but not limited to, participating in or aiding the following:

(f) Any departure from, or the failure to conform to, the minimal standards of acceptable and prevailing medical practice. Guidelines to be used by the Board in defining such standards may include, but are not restricted to:

1. Diagnosis. Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

2. Treatment. Use of medications and other modalities based on generally accepted and approved indications, with proper precautions to avoid adverse physical reactions, habituation or addiction.

3. Records. Maintenance of records to furnish documentary evidence of the course of the patient's medical evaluation, treatment and response.

MATTERS ASSERTED

1.

The Respondent is licensed to practice medicine in the State of Georgia and was so licensed at all times relevant to the matters asserted herein.

2.

Respondent was responsible for the diagnosis and treatment of patient F.D., (patient name omitted from public file copy to protect confidentiality) who was suffering from non-Hodgkin's lymphoma. Respondent's treatment of F.D. with chemotherapy and an autologous bone marrow transplantation procedure failed to comply with the minimal standards of acceptable and prevailing medical practice. Respondent further failed to follow standard protocol in performing the bone marrow transplantation procedure, including but not limited to proper maintenance of a sterile environment and proper use of antibiotics to avoid infection following the procedure. The patient died as a result of infection.

3.

Respondent was responsible for the diagnosis and treatment of patient T.H., (patient name omitted from public file copy to protect confidentiality) who was suffering from chronic granulocytic leukemia. Respondent's treatment of T.H. with chemotherapy and an autologous bone marrow transplantation procedure failed to comply with the minimal standards of acceptable and prevailing medical practice. Respondent further

failed to follow the standard protocol in performing the bone marrow transplantation procedure, including but not limited to proper maintenance of a sterile environment and proper use of antibiotics to avoid infection following the procedure. The patient died as a result of infection.

4.

Respondent was responsible for the diagnosis and treatment of patient J.V., (patient name omitted from public file copy to protect confidentiality) who was suffering from breast cancer, which had metastasized to the lungs, liver, brain and bone. Respondent's treatment of J.V. with chemotherapy and an autologous bone marrow transplantation procedure failed to comply with the minimal standards of acceptable and prevailing medical practice. Respondent further failed to follow the standard protocol in performing the bone marrow transplantation procedure, including but not limited to proper maintenance of a sterile environment and proper use of antibiotics to avoid infection following the procedure. The patient died as a result of infection and pulmonary collapse.

5.

Respondent was responsible for the diagnosis and treatment of patient C.B., (patient name omitted from public file copy to protect confidentiality) who was suffering from liver cancer. Respondent's treatment of this patient with chemotherapy and biologic response modifiers failed to comply with the minimal standards of acceptable and prevailing medical practice.

Additionally, Respondent concurred with a plan for this patient to undergo surgery to implant an infusion pump to infuse the liver with chemotherapy. The patient bled to death following this surgical procedure due to the inability of the patient's blood to clot.

6.

Respondent was responsible for the diagnosis and treatment of patient P.P., (patient name omitted from public file copy to protect confidentiality) who was suffering from colon cancer, which had metastasized to the liver. Respondent's treatment of this patient with chemotherapy and biologic response modifiers failed to comply with the minimal standards of acceptable and prevailing medical practice.

7.

Respondent was responsible for the diagnosis and treatment of patient M.B., (patient name omitted from public file copy to protect confidentiality) who was suffering from lung cancer which had metastasized to her left arm, resulting in a pathological fracture of the left arm. Respondent's treatment of this patient with chemotherapy and a bone marrow aspiration procedure, in which he filtered out all the cancellous bone and periosteum, failed to comply with the minimal standards of acceptable and prevailing medical practice.

ISSUES INVOLVED

1.

Whether Respondent's diagnosis and treatment of patients F.D., T.H., and J.V., including but not limited to his

methodology and use of chemotherapy and an autologous bone marrow transplantation procedure, fell below the minimal standards of acceptable and prevailing medical practice in Georgia and was in violation of O.C.G.A. §§ 43-34-37(a)(7), 43-34-37(a)(10), 43-1-19(a)(6), 43-1-19(a)(8), and Board Rule 360-2-.09(f)(1) and (2).

2.

Whether Respondent's diagnosis and treatment of patients C.B., P.P., and M.B., including but not limited to his methodology and use of chemotherapy, biologic response modifiers, and a bone marrow aspiration procedure, fell below the minimal standards of acceptable and prevailing medical practice in Georgia and was in violation of O.C.G.A. §§ 43-34-37(a)(7), 43-34-37(a)(10), 43-1-19(a)(6), 43-1-19(a)(8), and Board Rule 360-2-.09 (f)(1) and (2).

3.

Whether Respondent's recordkeeping with regard to the patients identified above fell below the minimal standards of acceptable and prevailing medical practice in Georgia in violation of Board Rule 360-2-.09(f)(3).

The foregoing, if correct, constitutes sufficient grounds for disciplinary action against Respondent, under O.C.G.A. § 43-34-37 and/or 43-1-19.

This Notice of Hearing is signed and attested by the Joint Secretary of the State Examining Boards, on behalf of the Composite State Board of Medical Examiners. The Board reserves

the right to amend this Notice of Hearing as provided in the Rules of the Joint Secretary, State Examining Boards.

This _____ day of _____, 1991.

COMPOSITE STATE BOARD OF MEDICAL EXAMINERS

MARJORIE E. LUCAS
President

(BOARD SEAL)

WILLIAM G. MILLER, JR.
Joint Secretary
State Examining Boards

Counsel:

JULIA B. ANDERSON
Staff Attorney
132 State Judicial Building
Atlanta, Georgia 30334
Telephone: (404) 656-4190

BEFORE THE COMPOSITE STATE BOARD OF MEDICAL EXAMINERS

STATE OF GEORGIA

IN THE MATTER OF:	*	
	*	
KENNETH B. ALONSO, M.D.,	*	DOCKET NO. 91-259
License No. 016011.	*	
	*	
Respondent.	*	

FINAL ORDER

STATEMENT OF PROCEEDINGS

The Composite State Board of Medical Examiners filed a Notice of Hearing on May 15, 1991, setting forth allegations upon which the Board sought to impose sanctions upon the license of KENNETH BRAULIO ALONSO, M.D., hereinafter referred to as "Respondent". Respondent is licensed to practice medicine in the State of Georgia. Respondent was served with the Notice of Hearing setting forth the date and time of the hearing and the appointment of a Hearing Officer for the Composite State Board of Medical Examiners, hereinafter referred to as the "Board", pursuant to O.C.G.A. § 50-13-13(5). In addition to scheduling the time and date for the hearing, the Notice of Hearing set forth the legal authority for the Board to act, and specified the factual allegations upon which the Board sought sanctions upon Respondent's license. The Board also set forth its legal authority for proceeding with sanctions against Respondent's license and, specifically, pursuant to O.C.G.A. § 43-34-37, Respondent was informed of the possible sanctions and specific statutes involved in connection with the matters asserted in the Notice of Hearing.

Hearings were held on various times from November of 1992 through January of 1994. The Initial Decision was docketed July 5, 1994. An Order originally scheduling the Notice of Review and appointed a Hearing Officer for the review was docketed August 15, 1994, calling for hearing on October 5, 1994, which was continued twice at the request and by agreement of all parties until December 7, 1994. Based upon a complete review

Final

of the record of testimony and evidence, the Initial Decision proposed by the Hearing Officer, and the arguments proffered before the Board, after deliberation in executive session the Board hereinafter makes its Findings of Fact, Conclusions of Law and Final Order as follows:

FINDINGS OF FACT

1.

The Board adopts the Findings of Fact contained in the Initial Decision.

CONCLUSIONS OF LAW

1.

The Board adopts the Conclusions of Law contained in the Initial Decision.

FINAL ORDER

The Respondent's license to practice medicine in the State of Georgia is hereby SUSPENDED for six (6) months, commencing on the date this Order is docketed. Additionally, the Respondent is PROHIBITED from treating cancer patients at any time in the future unless he should become a Board-certified oncologist. Respondent is placed on PROBATION for three (3) years, commencing on the date his suspension ends, under the following terms and conditions:

1. The Medical Coordinator or another representative of the Board shall be authorized periodically to review and inspect, at any reasonable time designated by the representative, Respondent's medical records and/or log records, as deemed necessary. Respondent shall have the right to be present during such inspection of records and the rights of privacy and confidentiality of patients shall be maintained. Respondent shall be available upon reasonable notice for personal interviews with the Medical Coordinator or other representative of the Board. Failure of Respondent reasonably to be available for inspection of his records or for personal interviews shall be considered a violation of the terms and conditions of probation.

2. The Respondent shall in all respects comply with Board Rule 360-2-.09 relating to diagnosis, treatment and record keeping.

3. The Respondent shall report in writing the filing of any malpractice suit naming him as a defendant or alleging malpractice by him. Such report shall be filed within thirty

(30) days after service of such suit upon Respondent or his receipt of notice of such suit, whichever is earlier. Respondent shall also report in writing any judgment or settlement of any malpractice suit or claim, regardless of any appeal. If any malpractice suit is pending at the time this Order is docketed, Respondent shall advise the Board of the existence and outcome of such suit.

4. Respondent shall supply a copy of the Order when it has been docketed, within ten (10) days from receipt of the docketed copy by Respondent to any person with whom Respondent is associated in practice, including other physicians or physician's assistant(s), and to any person or entity, except patients, by whom Respondent is employed as a physician in the State of Georgia. Respondent shall also be required to disclose the existence of and provide a copy of the Final Order to such individuals or entities in connection with any future application for institutional appointment, associated practice, utilization of a physician's assistant, residency program, fellowship program, or employment as a physician in the State of Georgia while this Order is in effect.

5. Respondent shall not utilize a physician's assistant or any other person to perform tasks that are prohibited by the terms of this order so as to circumvent any restriction, term, or condition of this Order.

6. If the Respondent leaves the State of Georgia for any period longer than thirty (30) consecutive days for the purpose of practicing medicine or to perform a residency, he shall notify the Board in writing of the dates of departure and return. Periods of residency or practice outside of Georgia shall not apply to the reduction of Respondent's period of restrictions or probation unless in a residency or fellowship program approved by the Board or otherwise authorized by the Board under such conditions as the Board deems acceptable. Respondent shall advise the Board of any change in his practice status and address of record.

7. Respondent shall abide by all State and Federal laws regulating the practice of medicine, the Rules and Regulations of the Composite State Board of Medical Examiners, and the terms of this Order. If Respondent shall fail to abide by such laws, rules, or terms, Respondent's license shall be subject to discipline, including revocation, upon substantiation thereof after notice and hearing. If revoked, the Board in its discretion,

may determine that the license should be permanently revoked and not subject to reinstatement.

8. The Respondent shall not treat cancer patients and shall do no medical work other than that for which he is Board certified.

9. Additionally, the Respondent shall pay a find of TEN THOUSAND DOLLARS ($10,000) to the Board within six (6) months of the date this Order is docketed.

10. Within sixty (60) days from the scheduled date of termination of this Order, the Composite State Board of Medical Examiners shall be authorized to review and evaluate the practice of Respondent. Should the Board receive information that Respondent has not complied with the terms of this Order or has since the entry of this Order otherwise failed to comply with the laws and rules regulating the practice of medicine, and should the Board further determine that reasonable cause exists for continuing the terms and conditions of this Order, the Board shall notify Respondent of its intent to extend the terms and conditions of this Order for a period not to exceed sixty (60) days, during which time the Board shall, after notice and hearing, issue a final determination with respect to whether Respondent has failed to comply with the terms of this Order or has otherwise since th entry of this Order failed to comply with the laws and rules regulating the practice of medicine.

This Order and its dissemination shall further serve as a public reprimand to the Respondent.

SO ORDERED this 5th day of January, 1995.

Composite State Board of Medical Examiners

(SEAL)

By: Larry E Brightwell, MD
LARRY E. BRIGHTWELL, M.D.
President

ATTEST:

William J. Miller
William J. Miller, Joint Secretary
Secretary of State, Examining Boards

stboard\alonso.fin

BEFORE THE COMPOSITE STATE BOARD OF MEDICAL EXAMINERS

STATE OF GEORGIA

IN THE MATTER OF:	Docket No. 91-259
KENNETH BRAULIO ALONSO, M.D. License No. 016011,	AG No. 96004-90-JBA
Respondent	

INITIAL DECISION

Hearings were held in this disciplinary matter on November 19, 1992; November 20, 1992; December 2, 1992; December 3, 1992; April 19, 1993; April 20, 1993; April 21, 1993; June 7, 1993; July 31, 1993 and October 5, 1993. Final arguments and briefs were filed on or about January 5, 1994. Throughout the proceedings, Robert G. Rubin, Special Assistant Attorney General, represented the State and Thomas C. Blaska, Esq., represented the Respondent.

FINDINGS OF FACT

1.

The Respondent is licensed to practice medicine in Georgia and was so licensed at all times relevant to these findings of fact. *Notice of Hearing and Answer; State's Exhibit Number 1.*

2.

The Respondent is Board certified in anatomic and clinical pathology, nuclear medicine and forensic medicine. The Respondent is not Board certified in internal medicine or oncology. *December 2, 1992 Transcript, pp. 10-24.*

Patient C.B.

3.

The Respondent admitted Patient C.B. to Atlanta Hospital on January 10, 1990. C.B. was a fifty-one year old female who prior to her admission had been diagnosed as having either a hepatoma or a metastatic tumor in the liver. Also prior to her admission she had been refused treatment by Emory due to the advanced state of her illness. *November 19, 1992 Transcript, pp. 47-50.*

At the time of her admission C.B. had an extremely poor performance status, was bedridden, not eating and jaundiced and had free fluid in the abdomen. Her liver was markedly enlarged. The Respondent made a diagnosis of hepatocellular carcinoma, which is hepatoma, or primary liver cancer. He also diagnosed her as having hepatic failure (liver failure) and massive ascites, which is fluid in the abdomen outside the intestines and outside the liver, between the intestines and the abdominal wall. *November, 1992 Transcript, pp. 53-57.*

The Respondent's plan during C.B.'s hospitalization was to improve C.B.'s nutritional status by hyperalimentation (placing a catheter deep in the vein going close to the heart) and to surgically place a hepatic artery catheter for direct infusion of chemotherapy to the liver. Dr. Heath, a surgeon, saw the patient in consultation and placed the catheter for hyperaliementation on January 12, 1990. Dr. Heath at that time also did a paracentesis, a withdrawal of fluid, from the abdomen. Laboratory analysis showed the fluid as having malignant cells. Next, the Respondent

began a chemotherapy regimen of interferon and somatostatin. Her laboratory values continued to be abnormal. An arteriogram was performed on January 17, 1990 to determine the patient's blood supply to her liver. Two days later, C.B. underwent surgery for placement of the hepatic artery pump and her liver was biopsed. There was a mass noted in the celiac axis area. During the surgery the patient slowly oozed blood. C.B. deteriorated and was returned to surgery to stop the bleeding. She died on the operating table. *November 19, 1992 Transcript, pp. 58-65.*

Dr. John Heath West, a medical oncologist practicing in Savannah who is Board certified in internal medicine and in medical oncology, reviewed the Atlanta Hospital records relating to Respondent's treatment of C.B. from January 10, 1990 through January 19, 1990 (State's Exhibit Number 2) *November 19, 1992 Transcript, pp. 21-28.* He testified that the Respondent's treatment of C.B. was unethical and below minimal standards of acceptable and prevailing medical practice. He testified that all of her blood clotting parameters were abnormal prior to the surgery and that the Respondent as her primary physician made very minimal steps to correct her clotting ability. The three values which deal with the ability of the blood to clot - platelet count, throthrombin time and partial thromboplastin time - were all abnormal. When those three factors are abnormal it is almost universal that the patient will bleed. He testified that as attending physician it was Respondent's job to get her ready for surgery and to cancel surgery. Dr. West determined from his review

of the records that C.B. bled to death. *November 19, 1992 Transcript, pp. 67-78 and 227-229.*

Dr. West further testified that the Respondent's use of interferon and somatostatin were below minimal standards because there is no medical evidence that those drugs are effective in treating metastatic cancer to the liver and hepatomas. *November 19, 1992 Transcript, pp. 73-74.* In fact, he noted that the use of interferon may have worsened her condition. It was contra-indicated for her low platelet count and her elevated liver enzymes. *November 19, 1990 Transcript, pp. 98-99.*

Dr. West testified that C.B. was not a candidate for the hepatitic artery pump for many reasons. The LDH test, an enzyme test of liver function, showed the patient had a massive elevation of LDH showing her liver had already deteriorated to the point she would not survive. C.B.'s bilirubin level was measured on the date of surgery. (Bilirubin is a breakdown of red blood cell metabolism and is processed through the liver.) Her level was 27.1, compared to upper level normal at 1.2. This test also showed the patient's liver to be very sick and the patient to be terminal. Additionally, the finding of cancer cells in the acidic fluid prior to surgery showed that the cancer was not localized in the liver. Dr. West testified that the pump is used only in highly selected patients whose metatosis is limited to the liver and who are otherwise viable. *November 19, 1992 Transcript, pp. 81-84.* Dr. John McLaren, M.D., an expert testifying for the Respondent, also

agreed that cancer cells in C.B.'s ascites was a contra-indication to the hepatic artery pump. *July 3, 1993 Transcript, p. 48.*

Dr. West further testified that the surgery was a high risk procedure in C.B.'s case. The surgical consent form was generic with no explanation of the risks involved. Dr. West testified it is below minimum standards for the Respondent not to have noted discussions with C.B. regarding risks involved and what her wishes would be regarding resuscitation. Additionally, Dr. West testified that the use of interferon and somatostatin were experimental. It was below minimal standards not to explain that to the patient and to receive written permission. *November 19, 1992, pp. 85-92; State's Exhibit Number 2-A.*

Dr. West testified that use of the hepatic artery pump was experimental in C.B.'s case because she was going to die no matter what. He stated, "she was not a candidate for the procedure, it should never have been done, it should never have been discussed." C.B. was not eligible for any protocol. *November 19, 1992 Transcript, pp. 92-94 and 100.* In Dr. West's expert opinion, Emory acted appropriately in refusing C.B. treatment since her death was eminent. He opined that C.B. should have been kept comfortable and should have received no active treatment. *November 19, 1992 Transcript, pp. 97-98.*

PATIENT P.P.

4.

The Respondent treated P.P. at Atlanta Hospital beginning on January 29, 1990, after he had been treated by Dr. Jolly. Dr.

Jolly had diagnosed the patient as having adenocarcinoma of the liver, presumably metastatic secondary from the colon. Dr. Jolly had treated P.P. by placing a catheter from the artery in the groin up into the liver. The patient received the chemotherapy drug 5 FODR around the clock for five days from Dr. Jolly prior to seeing the Respondent. *November 19, 1992 Transcript, pp. 105-106.*

When the Respondent saw P.P. he was complaining of pain in the location of the liver, cough, night sweats and poor appetite. He had two prior bouts of pneumonia. The patient was anemic with protein malnutrition and had lost thirty pounds. His performance status was Number 4. He was unable to function and was in the poor category. *November 19, 1992 Transcript, pp. 104, 107 and 108.*

Dr. Heath, a consultant, bronchoscoped the patient and found a mass in the right lower lobe of the lung. Respondent reviewed the biopsy and determined that it was suspicious for small cell carcinoma. Dr. Morehead, a consultant who saw the patient, diagnosed him as having undifferentiated cancer of the rectum, and that he most likely had a secondary primary, small cell cancer of the lung. Dr. Morehead recommended that the Respondent should go ahead with the colon resection, bowel modulation, chemotherapy and placement of the hepatic artery catheter. *November 19, 1992 Transcript, pp. 111-117.*

The patient signed a generalized consent form to be treated with Interleukin and Cimetidine. *State's Exhibit Number 3-A.* On January 29, 1990, the Respondent started P.P. on interferon and somatostatin. *November 19, 1992 Transcript, pp. 111 and 117.* Dr.

Escelera, a gastroenterologist, colonoscoped the patient to evaluate further the mass in the cecum and the colonoscopy report was negative. He noted that the patient did not want any surgical procedure that would compromise what he expected to live, forty-five months or more. P.P. asked to be discharged on February 5, 1990 in order to attend to urgent business. The Respondent planned for him to be readmitted to have the surgery. *November 19, 1992 Transcript, pp. 117-118.*

As an outpatient, P.P. received Interleukin, interferon and Cimetidine, which are biologic response modifiers. Then he was readmitted on February 16, 1990. From the time of his discharge on February 5, the patient's clinical condition had deteriorated and he was having diarrhea and sweats, his jaundice had rapidly progressed and he had become progressively unresponsive and stuporous. He died in the hospital on February 20, 1990, as a result of cardiopulmonary arrest and progressive liver failure. *November 19, 1992 Transcript, p. 118 and 122.*

Dr. West testified that the Respondent's treatment of P.P. fell below minimal standards. There is no data in the literature to support biologic response modifiers in P.P.'s situation. Dr. West suggested that the interferon may have hastened P.P.'s liver failure. Interferon can cause abnormalities of liver function tests, and P.P.'s liver function tests became more abnormal after P.P. received interferon. The use of Interleukin and Cimetidine were outside the minimum standards. Those drugs are still experimental. The Respondent offered P.P. a potentially toxic

treatment plan that could only make him worse. Because of P.P.'s low performance status at admission, his changes of responding to any treatment were "essentially nil." P.P. was not eligible for any protocol. Dr. West testified that symptomatic and palliative treatment would have met the standard of care in P.P.'s case. *November 19, 1992 Transcript, pp. 123-128.*

PATIENT M.B.

5.

M.B. was a 70 year old woman who had been seen by Respondent for three years with a metastatic adenocarcinoma of the lung. The Respondent hospitalized her on May 15, 1990 because of a non-healing fracture of the left humerus. At the beginning her performance status was good. Because of his results with his stem cell assay, the Respondent elected to use initially cytosar and nitrogen mustard as chemotherapy agents and the biologic response modifier interferon. M.B. had several admissions for chemotherapy. On the first treatment, she received a 7 day, 24 hour a day infusion of cytosar, the drug to which the stem cell assay showed the most sensitivity. However, M.B. developed a rash and the Respondent determined she was allergic to cytosar and discontinued it. He divided nitrogen mustard into four separate injections and gave them every six hours in four doses. He spread out some of the orders, 15 to 30 minutes for each injection. *November 19, 1992 Transcript, pp. 130-135.*

Dr. West testified that the Respondent's selection of drugs based upon stem cell assays was unorthodox and below minimum

standards. Nitrogen mustard and cytosar are not drugs which would ordinarily be used. The use of stem cell assays would be acceptable as part of a controlled clinical trial or protocol, but to pick an individual patient is below minimal standards. Dr. West further opined that the methodology of using nitrogen mustard was below minimum standards in that the nitrogen mustard should have been injected rapidly because the life of the drug is short. Spreading out the orders as Respondent did was below minimum standards. Most importantly, Dr. West noted that the Respondent gave two toxic drugs to M.B. when her white count was less than one thousand and her platelet count was six thousand. She could have gotten a major infection and died or she could have bled to death. November 19, 1992 Transcript, pp. 143-146 and 181.

Patient M.B. developed another metastatic lesion around the fifth lumbar vertebrae. The Respondent injected that lesion and the left arm lesion with 95% alcohol, resulting in neurological damage. Dr. West testified that he had never heard of this treatment for fractures. *November 19, 1992 Transcript, pp. 135-136.*

On May 15, 1990, the Respondent performed a bone marrow aspiration from M.B.'s hip and processed it. Dr. Chevres injected the autologous bone marrow into M.B.'s left humerus for treatment of her nonhealing fracture. M.B. signed a consent form, State's Exhibit 4-A. However, Dr. West testified that this procedure was experimental or investigational and the consent form does not state that the procedure is experimental or investigational.

Additionally, there was no IRB approval prior to the aspiration. Dr. West testified that the bone marrow aspiration and injection into the humerus was below minimal standards. Neither theoretical logic nor studies show that the aspiration and injection would be of any value. Because of prior radiation and alcohol injection the bone was nonviable and could not heal. *November 19, 1992 Transcript, pp. 139-142 and 147-148.*

PATIENT T.H.

6.

Patient T.H. was a forty-five year old woman with chronic myelogenous leukemia (a form of leukemia of the bone marrow), also known as chronic granulocytic leukemia, abbreviated CML or CGL. At the time the Respondent saw her she was receiving standard oral chemotherapy. On February 1, 1989 he harvested bone marrow from T.H. and subsequently purged and reinfused the marrow. After the transplantation, T.H. died of fungal infection. *November 20, 1992 Transcript, pp. 61-64 and 66 and 76.*

Dr. Steven Neal Wolff, M.D., who is Board certified in internal medicine and medical oncology and who is Director of the Bone Marrow Transplant Program at Vanderbilt University, testified that the purging process in autologous bone marrow transplants of patients with CGL is highly experimental because in CGL the marrow is essentially totally replaced by leukemic cells and normal cells are in small minority. Autologous bone marrow transplants have not been proven to be of any benefit to patients with CGL. Dr. Wolff testified that the consent form did not meet the minimal standards

because it did not give a rationale for the therapy or the purging of the bone marrow, the risks, the alternative therapies, or a statement that the procedure was investigational. *November 20, 1992 Transcript, pp. 7, 8, 69, 90-92.*

Dr. Wolff testified that in reviewing T.H.'s records, he saw no documentation that physiological adequacy of cardiac and pulmonary functions was ascertained. He testified that the failure to assess those functions would fall below the minimal standard of acceptable and prevailing practice. If those functions were evaluated and not documented, the lack of documentation would fall below minimal standards. *November 20, 1992 Transcript pp. 84-85.* Dr. Glenn Morehead, M.D., an oncologist involved in T.H.'s treatment, testified that T.H.'s heart and lung functions were evaluated and that she had a normal EKG, normal blood gas and normal electrolytes. Her chest x-ray was clear. *April 20, 1993 Transcript, p. 190.* Dr. Ronald George Steis, M.D., who is Board certified in medical oncology and who is experienced in the area of bone marrow transplants, disagreed that heart and lung functions were properly evaluated for T.H. He testified that pulmonary function is determined by how much blood is ejected into the heart with each beat. There was no evidence that any of these assessments were done. Cardiac function cannot be determined by looking at a biochemical profile or an EKG. *October 5, 1993 Transcript, pp. 29-30.*

Additionally, there was no record of pretransplant testing for herpes simplex, HIV, hepatitis, or CNV. Dr. Wolff testified that

HIV is an exclusion criteria for transplants except in highly experimental situations. Transplants would probably be detrimental to a patient with hepatitis. Dr. Ronald Steis testified that in bone marrow transplants herpes simplex can cause severe erosion of the inside of the mouth. If a patient tests herpes simplex positive, the patient can be given acyclovir medication to prevent a herpes simplex infection during the transplant. Dr. Steis explained the necessity of CMV testing in the event a transfusion might become necessary later. *October 5, 1993 Transcript, pp. 40-43.* Failure to perform this viral testing or to document this testing would fall below minimum standards. *November 20, 1992 Transcript, pp. 56-58 and 87.*

Dr. Wolff testified regarding the four drugs the Respondent used to purge T.H.'s marrow. He stated that Interleukin II is investigational and not approved for use as a purging agent. Bleomycin is not approved for treatment of CML. Mephosphanide is not available in this country, although it is used in Europe to purge bone marrow. Only Interferon has been approved for use in CML treatment. *November 20, 1992 Transcript, pp. 70-72.*

Dr. Steis was critical of the Respondent's report to Dr. Morehead *(Respondent's Exhibit Number 92)* in which he stated that no tumor was found in the purged marrow when examined under a microscope. He testified that there is no way to tell whether purging was successful by examining under a microscope. The Philadelphia Chromosome test, by a karyotype, must be done to determine whether the purging was successful in the case of CML.

This test could and should have been performed prior the transplant. *October 5, 1993 Transcript, pp. 55-57.*

Even more disturbing to the Hearing Officer, Dr. Steis testified that the Respondent's claim to use an anti-idiotype monoclonal antibody to purge T.H.'s marrow was nonsense. Myeloid leukemias (T.H.'s cancer) have no idiotype and therefore her marrow could not be purged with an anti-idiotype monoclonal antibody. *October 5, 1993 Transcript, pp. 23 and 63.*

Dr. Wolff was also critical of the dosing of the chemotherapy drugs to T.H. He noted that there was no documentation in the chart that ideal body weight was calculated or that the drugs were dosed based on ideal body weight. Drugs like cyclophosphamide, which was used, must be dosed based on the lesser of actual body weight or ideal body weight. *November 20, 1992 Transcript, p. 88. See also, October 5, 1993, pp. 38-40.*

After the reinfusion of bone marrow, the patient ran a fever. The antibiotic Gentamicin was used. Dr. Wolff testified that Gentamicin is renal toxic and should be dosed based on a patient's body size and renal function. If the kidneys are not working well, the normal dose cannot be given. Blood tests indicated T.H.'s kidneys were not excreting creatine but there was no measurement in the patient's chart of creatine clearance which is a more complicated test giving a baseline function of renal function. Dr. Wolff testified that to use Gentamicin blood levels must be measured within a few days to ascertain adequacy of levels. If the levels are too low, infection may not be treated adequately, but if

the levels are too high there may be kidney damage. He testified that the first Gentamicin level was done on March 20, well after it should have been measured. *November 20, 1992 Transcript, pp. 75 and 78.*

Dr. Wolff further testified that the Respondent's failure to administer Amphotericin B within 3-5 days of fever without documentation was below minimal standards. Amphotericin B was begun after seventeen days of intermittent fever. The patient died as a result of fungal infection following the transplantation. *November 20, 1992 Transcript, pp. 76 and 77.*

Dr. Morehead testified that he was T.H.'s primary treating doctor. However, on cross-examination Dr. Morehead admitted that the Respondent consulted with him on cancer aspects of the case and approved his course of treatment. Dr. Morehead and the Respondent made joint decisions regarding chemotherapy. The Respondent processed and reinfused the bone marrow. *April 20, 1993 Transcript, pp. 112, 125 and 180.*

PATIENT F.D.

7.

F.D. came to the Respondent with a diagnosis of poorly-differentiated lymphocytic lymphoma. At the time he came to the Respondent, the patient was not feeling poorly. There was a quote in the chart that he was still taking care of his own work at home. The Respondent harvested F.D.'s bone marrow on May 17, 1988. There was mention in the chart that no cancer cells were seen in the bone marrow. The marrow was purged with an antibody and with a

chemotherapeutic drug, VP-16. The Respondent then treated F.D. with cyclophosphamide and total body irradiation therapy. The patient then had bone marrow reinfused, and within a week become quite ill and died. *November 20, 1992 Transcript, pp. 95-98.*

Dr. Wolff testified that the Respondent fell below the minimal standards of acceptable and prevailing medical practice by failing to do HLA typing prior to the bone marrow transplant. Although the Respondent testified this was unnecessary in an autologous bone marrow transplant because there would be no risk of graft vs. host disease, both Dr. Wolff and Dr. Steis testified that transfusions post-transplant are not uncommon and transfusions with HLA-matched platelets yield better improvements in platelet recoveries. Both doctors testified that it would be impossible to HLA type a patient after transplant when no blood cells are available because of marrow suppression. *November 20, 1992 Transcript, pp. 55-56 and 100; December 2, 1992 Transcript, pp. 202-204; October 5, 1993 Transcript, pp. 46-47.*

Dr. Wolff further found the Respondent's treatment of F.D. below minimal standards because there was no organ function evaluation prior to the transplant and there was viral testing prior to the transplant. *November 20, 1992 Transcript, pp. 100-101.*

Dr. Wolff further found the Respondent's use of total body irradiation on this patient fell below minimal standards in that F.D. previously had received a large amount of radiation therapy to which the liver was exposed. He assumes that the radiologist

considered the prior radiation treatment and reduced the amount of radiation therapy because of fear of toxicity to the liver. Other therapeutic regimens that did not contain radiation could have been given at effective levels and should have been substituted. *November 20, 1992 Transcript, pp. 102-104.*

Dr. Wolff found no documentation of the basis for calculating the amount of chemotherapy used. Further, he found no justification for giving F.D. interferon after F.D. was catastrophically ill with liver disease. F.D. died of hepatic necrosis. Finally, Dr. Wolff testified that it was below minimal standards not to have a well-documented consent form specific to the total body irradiation and the autologous bone marrow transplant. *November 20, 1992 Transcript, pp. 110-114.*

PATIENT J.V.

8.

J.V. had metastatic breast cancer which had spread to her liver, lung, brain and bone. She also had multiple sclerosis and was bedridden with a neurologic bladder. When the Respondent performed the autologous bone marrow transplant on J.V. there was evidence that her renal function was impaired, although the definitive test of creatinine clearance was not done. Her records showed no cardiac and pulmonary function tests being done prior to her transplant. Additionally, there was no evidence of viral testing. The failure to do physiological testing and viral testing was below minimal standards. *November 20, 1992 Transcript, pp. 115-117.*

Additionally, the Respondent performed no evaluation of J.V.'s bone marrow prior to the harvest. The Respondent testified that this was unnecessary because he knew there was tumor in the marrow, and the tumor would be purged. However, Dr. Wolff testified that generally breast cancer patients are not used for transplantation autologically because of the metastasis to the bone. Major studies involving breast cancer patients require the bone marrow to be negative for cancer for transplanting. When the bone marrow is involved in the cancer, it is highly investigational because of the purging. Dr. Wolff testified that although J.V. was a poor candidate for transplantation, there is nothing on the record to indicate this was discussed with her. There is no signed consent form which would meet the minimal standards of acceptable and prevailing medical practice. *November 20, 1992 Transcript, pp. 118-120.*

Dr. Wolff testified the evaluation criteria for transplant eligibility fell below minimal standards. *November 20, 1992 Transcript, p. 122.* Additionally, he found the Respondent's treatment of J.V. to be below minimal standards. Some antibiotics used following the transplant were inadequate such as Gentamicin and Cis-Platinum, which are renal toxic (and the patient had renal insufficiency. Additionally, attempts at managing her fluid balance were below minimal standards. She was given a lot of fluids and gained weight and died of pulmonary edema (flooding lungs with fluid). The failure of a technician to properly hook up her respirator led to an inability to provide appropriate liter

volumes and oxygen concentration to her prior to her death. Although the Respondent was not directly responsible for this error, as her physician he was responsible for ascertaining that the total care of the patient was adequate. Also before her death, J.V. had a fungus infection. The Respondent's failure to implement adequate anti-fungal therapy fell below minimal standards. *November 20, 1992 Transcript, pp. 124-129.*

9.

The Hearing Officer in making the findings of fact above, carefully reviewed testimony offered by the Respondent and his experts, Dr. Freeman, Dr. Morehead and Dr. McLaren. Even though the Respondent and his witnesses offered testimony that minimal standards were met in the care of the patients, each of those witnesses had personal involvement with the care of one or more of the patients. Their testimony clearly emitted self-interest. In contrast, the State's expert witnesses had no involvement with any of the patients at issue and offered objective opinions regarding the Respondent's care and treatment of the patients. Additionally, the credentials of the State's three expert witnesses, Dr. West, Dr. Wolff and Dr. Steis, were stellar. Their detailed explanations of the procedures involved and their detailed explanations regarding why the Respondent's treatment failed to meet minimal standards were both understandable and convincing. The Respondent's witnesses' testimony conflicted with many of the findings of fact set forth above. However, the Hearing Officer did not find their testimony to be persuasive or credible.

CONCLUSIONS OF LAW

Based upon the findings of fact above, the Board has the authority to sanction the license of the Respondent to practice medicine in Georgia pursuant to O.C.G.A. § 43-34-37(a)(7) and (a)(10); O.C.G.A. § 43-1-19(a)(6) and (a)(8); and Board Rule 360-2-.09.

RECOMMENDED SANCTION

The Respondent's treatment of the six patients who are the subject of this Initial Decision not only fell below minimal standards but was also unethical and dangerous. The State in its brief stated that it takes no position on whether the Respondent's conduct merits suspension. However, the Hearing Officer recommends that the Board suspend the Respondent's license to practice medicine in Georgia for six months, commencing on the date this Order becomes final. Additionally, the Hearing Officer recommends that the Board prohibit the Respondent from treating cancer patients at any time in the future unless he should become a Board-certified oncologist. The Hearing Officer finally recommends that the Board place the Respondent on probation for three years commencing on the date his suspension ends, under the following terms and conditions:

(1) The Medical Coordinator or another representative of the Board shall be authorized periodically to review and inspect, at any reasonable time designated by the representative, Respondent's medical records and/or log records, as deemed necessary. Respondent shall have the right to be present during such

inspection of records and the rights of privacy and confidentiality of patients shall be maintained. Respondent shall be available upon reasonable notice for personal interviews with the Medical Coordinator or other representative of the Board. Failure of Respondent reasonably to be available for inspection of his records or for personal interviews shall be considered a violation of the terms and conditions of probation.

(2) The Respondent shall in all respects comply with Board Rule 360-2-.09 relating to diagnosis, treatment and recordkeeping.

(3) The Respondent shall report in writing the filing of any malpractice suit naming him as a defendant or alleging malpractice by him. Such report shall be filed within thirty (30) days after service of such suit upon Respondent or his receipt of notice of such suit, whichever is earlier. Respondent shall also report in writing any judgment or settlement of any malpractice suit or claim, regardless of any appeal. If any malpractice suit is pending at the time this order becomes final, Respondent shall advise the Board of the existence and outcome of such suit.

(4) Respondent shall supply a copy of the Order when it becomes final, within ten (10) days from receipt of the docketed copy by Respondent to any person with whom Respondent is associated in practice, including other physicians or physician's assistant(s), and to any person or entity, except patients, by whom Respondent is employed as a physician in the State of Georgia. Respondent shall also be required to disclose the existence of and provide a copy of the final Order to such individuals or entities

in connection with any future application for institutional appointment, associated practice, utilization of a physician's assistant, residency program, fellowship program, or employment as a physician in the State of Georgia while this Order is in effect.

(5) Respondent shall not utilize a physician's assistant or any other person to perform tasks that are prohibited by the terms of this Order so as to circumvent any restriction, term, or condition of this Order.

(6) If the Respondent leaves the State of Georgia for any period longer than thirty (30) consecutive days for the purpose of practicing medicine or to perform a residency, he shall notify the Board in writing of the dates of departure and return. Periods of residency or practice outside of Georgia shall not apply to the reduction of Respondent's period of restrictions or probation unless in a residency or fellowship program approved by the Board or otherwise authorized by the Board under such conditions as the Board deems acceptable. Respondent shall advise the Board of any change in his practice status and address of record.

(7) Respondent shall abide by all State and Federal laws regulating the practice of medicine, the Rules and Regulations of the Composite State Board of Medical Examiners, and the terms of this Order. If Respondent shall fail to abide by such laws, rules, or terms, Respondent's license shall be subject to discipline, including revocation, upon substantiation thereof after notice and hearing. If revoked, the Board in its discretion may determine

that the license should be permanently revoked and not subject to reinstatement.

(8) The Respondent shall not treat cancer patients and shall do no medical work other than that for which he is Board certified.

(9) Additionally, the Respondent shall pay a fine of $10,000.00 to the Board within six months of the date the Order becomes final.

(10) Within 60 days from the scheduled date of termination of this Order, the Composite State Board of Medical Examiners shall be authorized to review and evaluate the practice of Respondent. Should the Board receive information that Respondent has not complied with the terms of this Order or has since the entry of this Order otherwise failed to comply with the laws and rules regulating the practice of medicine, and should the Board further determine that reasonable cause exists for continuing the terms and conditions of this Order, the Board shall notify Respondent of its intent to extend the terms and conditions of this Order for a period not to exceed sixty (60) days, during which time the Board shall, after notice and hearing, issue a final determination with respect to whether Respondent has failed to comply with the terms of this Order or has otherwise since the entry of this Order failed to comply with the laws and rules regulating the practice of medicine.

This Order and its dissemination shall further serve as a public reprimand to the Respondent.

The Initial Decision shall become the decision of the Board without further proceedings unless within thirty (30) days of the Notice of this Initial Decision an application is filed by the Respondent for review by the Board or the Board on its own motion issues an order for review of the Initial Decision.

This 5th day of July, 1994.

Ethel D. Andersen
Hearing Officer for the State
Examining Boards